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ABSTRACT

The community mental health movement started with the purpose of providing services dealing with problems and issues specific to individual communities. As the movement grew, it took on the responsibility of delivering services to the "underserved" populations of this country, including children, the elderly, minority groups, and rural-area residents. American Indians also fit into this category, because they have occupied the unique position of being wards of the United States government, confined to reservations, or, in some cases, terminated as an ethnic entity. Dependency, negative self-concepts, and limited access to either the traditional Indian culture or the majority culture are examples of problems leading to feelings of depression and cultural ambivalence. Although community mental health concepts such as outpatient care, 24-hour emergency care, consultation, and education are useful in Indian mental health programs, limitations of population size and lack of personnel prevent the development of inpatient care and partial hospitalization services. Any mental health program designed for American Indians should also include a strong cultural element in order to enhance program effectiveness. (Author/HLM)

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The Community Mental Health Movement: Implications for American Indian Mental Health

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The Community Mental Health Movement: Implications for American Indian Mental Health

The community mental health movement, begun in the early 1960's, had as its original intention and focus, five basic mandates. These were: (a) inpatient care, (b) outpatient care, (c) partial hospitalization, (d) 24-hour emergency care, and (e) consultation and education to the community. It was hoped that community mental health centers following these mandates would provide services dealing with the problems and issues specific to the community where each center was located (Mann, 1978).

As the community mental health movement grew, it began to encompass other areas. Most recently, this growth has included providing services to the "underserved" populations of this country. Among those defined as "underserved" are children, the elderly, minority groups, and rural communities (Dolan, 1973). As American Indians often fit this category, this paper will focus on the applicability of community mental health concepts to American Indian mental health.

To better understand the implications of the community mental health movement for American Indians, it is helpful to have some knowledge of the history of the movement. Although some of its early roots were in the moral treatment philosophy of the 1800's, a more recent impetus for community mental health came from three important developments in the 1950's. These were (a) substantial breakthroughs in the field of psychopharmacology, (b) growing acceptance of the "therapeutic community" (Jones, 1968), and (c) geographic decentralization of large state mental hospitals (Bloom, 1977).

With the development of the major tranquilizers, treatment of chronic patients was far more effective and faster than before. Many people, who previously would have needed hospitalization, were able to function in the community. Those patients requiring inpatient care functioned better and presented less management problems than before the advent of the antipsychotic drugs. With many more patients being maintained in the community, outpatient programs were needed to meet these special requirements.

Concurrent with the growing use of the major tranquilizers was the development of the concept of the therapeutic community. Jones (1968) was one of the important leaders of this movement which encouraged the building of democratic communities within the hospital. Ideally, this would allow for input into treatment plans from both the staff and patients, facilitating more effective use of psychological treatment.

The third factor was the geographic decentralization of the large state hospitals. What this meant was patients were assigned to wards based on their previous place of residency, rather than on treatment needs. Although decentralization grew out of administrative problems, it unintentionally provided a link between outside communities and the institution (Bloom, 1977). From these three factors grew the idea of outpatient, community-specific treatment.

From the changes in attitudes about, and treatment of, mental illness and health in the 1950's, it became apparent that new, innovative programs were needed. To determine the mental health needs of the nation, the Joint Commission on Mental Illness and Health was formed. In 1961, the final report of the Joint Commission was published. It called for treatment facilities based on the size and needs of individual communities, as well as expanded mental health education to teach the public about psychological disorders and to reduce the stigma and rejection of the mentally ill.

Based on the recommendations of the Joint Commission, President Kennedy made his historic speech in 1962. In this speech, he called for legislation to "seek out the causes of mental illness and mental retardation and eradicate them" and for Congress to "authorize grants to the States for the construction of comprehensive community mental health centers;" and "until the community mental health center program develops fully, . . . that the quality of care in existing State mental institutions be improved. . . ."

Kennedy's landmark speech was followed by the enactment of the Community Mental Health Center's Act of 1963. This Act provided for the construction and staffing of centers and established guidelines for client care. Among these guidelines were the five mandates previously mentioned. The main purpose of these centers was to make mental health services available in communities all over the United States and to put new techniques of crisis intervention and psychological treatment into practice (Bloom, 1977). While this was an impressive beginning, as the community programs were implemented, it became apparent that these centers would be required to meet needs not originally defined.

In 1968, the need for additional programs to handle specific problems was recognized with the Alcoholic and Narcotic Addict Rehabilitation Amendments. What inclusion of these Amendments did was to establish community mental health centers as facilities for treating social problems as well as individual psychiatric disorders and chronic patients. It also allowed for more flexibility in the roles of professionals in centers, i.e., the possibility for professionals to act as agents of social change.

The focus on social issues and special populations in the community mental health movement continued with the addition of child mental health and drug abuse services in 1970. In 1973, Dolan suggested the inclusion of

"underserved" populations in community mental health. While some steps have been taken to address the problems of the "underserved," notably the child mental health addition, a good deal of needs assessment and program design is still needed for many minority groups and rural populations.

In summary, the community mental health movement evolved to deliver services to a wide range of populations and their specific problems. It has progressed from a limited beginning in the 1960's into a primary means of addressing individual, community, and social problems. Now, at the start of the 1980's, more attention is being focused on the "underserved" groups of this country. As American Indians often fit this category, being a minority group and often living in rural areas, the remainder of this paper will examine the status of American Indian mental health and the impact of the community mental health movement.

A great deal has been written about the various problems facing American Indians today. Unfortunately, in this literature a tendency exists to view all Indians as the same, regardless of background and/or tribal affiliation. Therefore, the Colville reservation of northcentral Washington will be the case example for specifics presented in this paper. Although the Colville reservation is unique in many cultural and economic aspects, many of the problems are similar to those found on other reservations.

Three agencies share responsibility for social and mental health programs at Colville. These are Indian Health Service (IHS), Bureau of Indian Affairs (BIA), and Colville Tribal Programs. As the roles of these agencies are alike, it is more useful to understand the total mental health picture than to focus on individual agencies. The rest of this paper will examine some of the social and psychological problems of American Indians, with special attention to Colville, and how community mental health concepts could help meet the needs of this unique population.

On an outpatient basis, a wide variety of psychological, social, and community issues are handled by social and mental health workers. Approximately 71% of the professional's time is committed to direct services involving such problems as depression, anxiety, suicide, drug/alcohol abuse, marital conflicts, child and youth problems, social and economic adjustment, and crisis intervention (Colville Tribal Health Plan, 1979). While many of these problems are similar to those seen at other mental health centers, crucial differences do exist.

One of the most important differences has to do with the hypothesized causes of psychological difficulties. American Indians have occupied the unique position of being wards of the United States government, being confined to reservations, and in some cases, being terminated as an ethnic entity. This has contributed to the dependency of many Indians on the government for their existence, with the result of many long-reaching and complex implications for mental health. In addition, the use of boarding schools and the imposition of non-Indian religions have contributed to the breakdown of traditional Indian culture, leaving a large portion of Indians with the idea that they and their culture are bad (Harrison & Marcelley, 1977; McFee, 1972).

Dependency, negative self-concepts, and limited access to either the traditional Indian culture or the majority culture often lead to feelings of depression and cultural ambivalence (French, 1976; Metcalf, 1976). While not all of those clients presenting with depression at Colville attribute their depression to dependency or cultural ambivalence, a good many of these people express feelings of low self-esteem, lack of control over life events, and feelings of pessimism. It is crucial to treat adequately as it is thought to lead to the more severe problems of suicide, alcoholism, and violence (Frederick, 1973), all of which are of paramount concern on many reservations.

As well as the large number of clients being treated on an outpatient basis (200 per month), the severity of problems seen is greater than in other

community mental health centers. One possible explanation for this is the cultural value of stoicism and a lack of overt emotionality (Spindler & Spindler, 1971). Therefore, when an Indian seeks out professional help, it is usually because the problem has reached crisis proportions and the individual feels unable to cope. This pattern of help seeking is important to understand as it has an effect on the type of intervention offered by mental health programs.

In addition to people attempting to manage on their own for as long as possible, other reasons exist for the higher level of severity of problems handled on an outpatient basis. First, at the present time, no facilities exist for inpatient care or partial hospitalization. This means that the majority of chronic, severely disturbed patients are seen through outpatient clinics. Second, what the mental health worker may see as a problem, the community and individual person may not (Gaines, 1979). For example, mental health workers may view a large family as a possible source of stress while the Indian person views it as a positive support system.

The type of intervention on an outpatient basis is often crisis intervention due to the higher tolerance of Indian people for some problems. Thus, when help is sought, it is usually because the individual perceives him/herself to be in crisis. Counseling may only be three or four sessions, but it is not uncommon for these sessions to run as long as 4 hours. The nature of the problems seems to demand an intensity of intervention that may not be found in other community mental health centers. The mental health worker will often be called at home and must be flexible in both working hours and counseling skills to handle the myriad of problems seen on the reservation. As many of the issues and problems seen at Colville can be traced to social and cultural factors, the mental health worker should be able to identify these factors and work within the cultural framework of the community and the individual client (Smith, Burlew, Mosley, & Whitney, 1978).

One of the cultural factors which may influence therapeutic interactions is the client's assumptions and perceptions about the abilities of the therapist. In many traditional Indian cultures, the medicine person was viewed as having special skills in helping others and knowing, without always being told, what a person's problem was (Jilek, 1974). While mental health workers can offer insight into problems, they cannot always "see" and "heal" the way a medicine person could. It is important that both client and therapist understand the role of the therapist and any assumptions the client may have regarding therapy.

Referrals for outpatient care are also somewhat unique at Colville. It is quite common to receive a request for intervention from someone being held in one of the local jails. These are not court referrals, rather they come from the jailer, the family of the prisoner, or are a self-referral from the prisoner. Therapy may be conducted in the jail and contact with the mental health worker will often continue, whether it is part of the court sentence or not.

In summary, outpatient care consists of a wide variety of problems, often crisis oriented, and therapy is usually short-term but of high intensity. Referrals are often self-made or by word-of-mouth and therapy may take place in jails, homes, and other locations outside the clinic building. The bulk of the professional's time is committed to direct services and will often require the mental health worker to be available around the clock.

Inpatient care for psychiatric patients is done off the reservation due to a lack of a facility. As the population of the reservation is small, it is not feasible to build a facility but off-reservation treatment poses some large problems. Often the distance to the inpatient facility is large and presents problems for the family of the patient as it limits visiting time and support the family can give. Long distances can also limit the contact

the reservation personnel have with the patient and the staff of the inpatient facility. Good working relationships between staffs are desirable and long distances may hinder this.

Another important problem with off-reservation hospitalization is that psychiatric problems can be exacerbated by the removal of the patient from familiar surroundings. People tend to become more stressed and less oriented when placed in settings where they are unsure of the social structures and their expected roles. In patients with moderate to severe psychological problems, this can be a catalyst for an acute break. Providing the institution staff with knowledge about the cultural importance placed on family and friends as support may help alleviate some of these difficulties and facilitate treatment.

Another problem which can arise if off-reservation, non-Indian hospitals are used is one of alienation between staff and patient. If the institution staff has only limited knowledge of Indian culture and values and reacts to the Indian patient on the basis of stereotypes, this may limit communication and have an inhibiting effect on treatment. It is important that the staff have an understanding of what hospitalization means to the patient and be somewhat flexible in fitting treatment to the beliefs and values of the patient (Gaines, 1979; Townsend, 1979).

As mentioned earlier, many Indian patients may be dealing with problems resulting from social pressures of reservation life. A common consequence of this stress is excessive alcohol consumption with a large number of people being treated in off-reservation facilities for detoxification. While it is acknowledged that this problem can be frustrating for hospital staff, it is helpful to both the staff and patient if treatment is aimed at helping the patient to cope in a more constructive manner with day-to-day problems. Again, if the institution staff is sensitive to the culture of the patient, this may help facilitate communication and aid treatment.

Partial hospitalization (or day treatment) is also not available on the reservation at this time although there is discussion on how to remedy this situation. As with outpatient care, ambulatory chronic patients are seen either through clinics on the reservation or in off-reservation facilities. Because the cultural value is to keep the family at home and together, if at all possible, many patients who could benefit from partial hospitalization receive little or no professional care. The possible therapeutic partnership of family and professional does not occur and the strengths of the family support are not utilized.

For good day care programs off the reservation, many of the same steps need to be taken to incorporate cultural aspects into the treatment plan. This may include teaching people culturally oriented living and social skills, i.e., fishing, root digging, bead work, and dancing. Again, the hospital staff should be flexible in their formulation of treatment and allow inclusion of the patient's beliefs and values. Contact between reservation staff and the day care facility should also be maintained to help the patient return to the community with a minimum of difficulties.

For day care facilities on the reservation, many of the same principles apply, i.e., flexibility in treatment and incorporation of culturally oriented social and living skills. It might also be valuable to have a traditional medicine person available to give patients insight into cultural interpretations of their illness. This element can be a very potent source of support to both the staff and patients of a reservation facility. Recreational activities incorporating traditional culture, such as dancing, drumming, and shawl-making, may also promote social interactions of therapeutic value.

Twenty-four hour emergency care is another area where the small population of the reservation is a limitation to the type and amount of resources available.

Twenty-four hour care is handled by the tribal police, county police, tribal and county mental health workers, hospitals near the reservation, tribal ambulance, and the local crisis line. Emergencies can include anything from alcohol intoxication to marital conflicts. Common emergencies range from suicide attempts, accidents, and violence to finding a family a place to live (Colville Tribal Health Plan, 1979).

It is important to realize the nature of most of these emergencies is not very different from those seen in other health facilities, rather, it is the extremely high number of emergencies in a small, rural population that is of concern. It is common for the person in crisis (or a family member) to call in a mental health worker at the time of the crisis or shortly after. In this setting the mental health worker is often seen as part of the patient's support system. Frequently, the worker will be called on to mediate between the patient and emergency personnel or to help make immediate treatment decisions.

As with inpatient care and partial hospitalization, it is crucial that off-reservation personnel be sensitive to the values of the patient. Some Indian people may have complete trust in the health personnel and expect the health workers to understand their problems without a large amount of history taking. Again, not all health professionals have this ability but it is important that these assumptions of the patient's be understood. Emergency, and other health personnel, should have some awareness of the local culture and be able to acknowledge and accept the values of the patient. This may be a very good way of lowering barriers between Indian patients and non-Indian personnel.

As stated previously, many Indian people will minimize their problems and not call for professional help until the issue has reached crisis proportions. When this occurs, the person may feel out of control and actually seek hospitalization or even jail as an artificial means of control. While this may not be uncommon with non-Indian people, it is important that emergency personnel

understand what the patient is seeking by asking for help. This is where the sensitive mental health worker can be of enormous value.

As mentioned earlier, alcohol abuse and addiction are viewed as one of the most serious problems facing many American Indians (Frederick, 1973). Many emergency calls are related to alcohol, whether it is for detoxification problems or car accidents. It may be hard for emergency room personnel to maintain patience and objectivity when dealing with the same people over and over, but the staff should have sensitivity to the role alcohol may play in the lives of Indian people and not deal with the issues from negative stereotypes.

In emergency situations, many Indian people will present with family and friends. This may be a hinderance to the medical and emergency personnel but it may make adjustment for the patient easier and facilitate treatment in the long run. If possible, both the emergency room staff and institution should be aware of this cultural value and help make provisions to incorporate this support into the treatment plan. This is where the sensitive mental health worker can serve a valuable role as liaison between staff and patient.

The last area is that of consultation and education to the community. To reiterate, the majority of the professional's time is committed to direct services with very little time left for training, consultation, and community education. That is not to say that Indian mental health professionals do not view these as important. Indeed, as pointed out in this paper, education to the community, both on and off the reservation, is crucial. For education to become more feasible, it will be necessary to have a larger mental health staff to eliminate some of the overload now being handled by mental health and social workers.

The type of education and consultation to communities on and off the reservation will vary with the group being addressed. Education to the

reservation community may center around community issues such as the high rate of suicide on the reservation. It might also focus on health problems such as diabetes or otitis media. No matter what the specifics of the educational program, it is important that it address what the reservation community itself has defined as crucial issues.

One area which is now receiving attention is how Indian people have incorporated many of the negative stereotypes of Indians into their belief systems. Education of how these are stereotypes and not necessarily true, needs to be taught to all Indians, regardless of age. This is especially true in the area of alcohol and Indians. The myth of the "drunken Indian" is one many Indian people believe with devastating psychological effects. It is important to teach Indian people how and when to drink and to give them coping skills which encourage and incorporate the positive things about being Indian and reservation life.

For off-reservation consultation and education, it is of the utmost importance that non-Indian personnel be made sensitive to Indian culture and values. Working relationships with information being passed freely from reservation to off-reservation agencies might help strengthen all programs involved and facilitate communication between Indian and non-Indian people. It is also important to help non-Indian people understand how the definition of "deviancy" can vary from culture to culture and help build programs around the cultural and community defined problems.

This paper has been a brief summary of the status of American Indian mental health in terms of community mental health concepts. While some of the concepts (outpatient care, 24-hour emergency care, and consultation and education) are applicable and in use in Indian mental health, limitations of population size and lack of personnel have prevented the development of inpatient

care and partial hospitalization. It has also been stressed in this paper that, no matter what the program or facility is, some attempt should be made to include a strong cultural element in treatment programs.

American Indians are in a transition phase in many aspects at this time due to the Indian self-determination act. This act was to encourage individual reservations and tribes to build their own programs. This is congruent with the basic tenent of community mental health to provide mental health care to fit the needs of each community. To reach this goal, however, it will be necessary to enlarge the mental health staff and to train staff to deal with a wide variety of problems and situations.

It will also be necessary to begin to assess the problems of the community, as defined by the community, and build health and social programs based on these community definitions. Mental health programs and personnel need to be flexible and innovative, incorporating modern psychological methods with culturally oriented treatment methods. For those people with strong cultural identification, it might be important to include traditional medicine people and natural helpers from the community. Above all, it is crucial that Indian people be involved in mental health programs from the definition of the problem through design and implementation of programs.

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